Commentary: Factors affecting HIV/AIDS-related stigma and discrimination by medical professionals

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HIV/AIDS is a highly stigmatized health condition—people living with HIV/AIDS (PLWHA) are more likely to be discriminated against than patients with most other health conditions. Li et al.¹ found that Chinese health professionals displayed more judgemental attitudes and less willingness to interact, even casually, with a hypothetical patient with HIV/AIDS than one with Hepatitis B. Such HIV/AIDS-related stigma and discrimination can reduce the quality of treatment and health care received.² It can also negatively affect the experience and self-esteem of HIV-positive patients.³ Thus, even where HIV-positive people have access to health care, they may not experience better health and quality of life as a result.

Since the late 1980s, there has been keen research interest in establishing the factors that affect HIV/AIDS-related stigma and discrimination among health care professionals. The factors affecting HIV/AIDS-related stigma and discrimination among health care professionals that have received most attention include exposure to PLWHA, level of medical education, knowledge about HIV and perceived infection risk at work. Other factors that have not received sufficient attention include type of medical profession, type of health facility, profile of patients seen and nature of contact with PLWHA.

Although prior exposure to PLWHA usually decreases stigma and discrimination by health care professionals,⁴ certain kinds of exposure highlight status differentials between patients and health care professionals rather than creating more empathy. In a study on nurses, Sadow et al.⁵ found that medical education can in fact increase the stigmatizing attitudes of nursing students, as it often promotes the idea that there is a status differential between nurses and patients. As Li and Cole⁶ note:

Frequently medical education about AIDS, like medical education in general, relies on a cognitive model with the implicit assumption that increased knowledge and skills will lead to improved care. Support for this assumption is especially weak in the case of AIDS, since anxiety and stigmatization play such a large part in the social response to this disease (p.305).⁷

Li et al.¹ found that higher-status medical professionals with more education were more likely to discriminate against PLWHA. This may be due to increased status differentials between medical professionals and patients, as Sadow et al.⁶ suggest, but in hospital settings it may also be due to the increased capacity to exploit status differentials between medical professionals—compared with junior doctors, for example, senior doctors have more power to delegate what they see as high-risk tasks with HIV-positive patients. It may also be linked to the kinds of HIV/AIDS cases seen by senior consultants and referral hospitals, which are more difficult to treat,⁴ and thus challenge the ability of health professionals to ‘do their job’.

Research has long attempted to establish the relationship between knowledge about HIV, fear of infection and stigma (blaming and shaming) or discrimination. Some studies find a close relationship,⁵ and others do not.⁸,⁹ These results may be influenced by cultural acceptability of prejudice towards those defined as risk groups and the stage of the epidemic. Li et al.¹ found that it was fear of infection rather than HIV knowledge which was related to health professionals’ willingness to interact with PLWHA. Fear of infection had a positive relationship with prejudicial attitudes in the case of nurses, but not in the case of doctors and technicians.

The kind of knowledge being tested in such studies is often general knowledge about transmission modes—it may be useful to measure perceived risk of infection relating to medical care and specific medical procedures.¹⁰ Fear of infection in health care workers may be more likely to be related to the latter more specific forms of knowledge, to likely exposure, and to the capacity to manage the risk of infection (e.g. availability of gloves when necessary) than to general knowledge about transmission modes. The nature of exposure to risk of infection would vary

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depending on the kinds of work being done, for example by
different professional categories of health care workers.

In conclusion, interventions to reduce HIV/AIDS-related
stigma in health care settings need to address different patterns
of stigma and discrimination among medical professionals in
different positions of authority and professional roles. The use
of case vignettes is an appropriate mechanism of eliciting such
patterns where questionnaires explicitly probing stigma might
not be as effective. Observing discriminatory practices in
hospitals might also be considered as a research tool. Medical
education in general, and education about HIV and AIDS, will
not necessarily reduce stigma and discrimination unless it
reduces specific fears of infection in the workplace. This has to
be coupled with access to necessary equipment and procedures
to ensure that health professionals can manage the risk of
workplace infection appropriately. With an estimated 70,000
new infections per year in China, concentrated amongst risk
groups who are most likely to experience stigma from health
professionals, evidence of prejudicial attitudes to
HIV-infected individuals amongst health workers is of concern.
There remains the opportunity to impact on the future of the
epidemic in China through focused interventions for these
groups, and an embracing health service for HIV-infected
individuals is a key component of this response.

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